

**WICHITA UROLOGY GROUP PA**

<b>PROVIDER:</b> _____	<b>ACCT:</b> _____	<b>APPT DATE:</b> _____
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In order to serve you properly we need the following information completed entirely. All information will be kept confidential. Please use black or blue ink and print clearly.

**Patient Information**

Patient Full Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Address: \_\_\_\_\_ APT : \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
SSN: \_\_\_\_\_  Male  Female DOB: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Family Doctor: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_  
**1st ER Contact:** \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_  
**2nd ER Contact :** \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_  
Pharmacy: \_\_\_\_\_ Address (major intersection) \_\_\_\_\_  
Check appropriate box:  Single  Married  Divorced  Widowed  Separated  
Spouse's Name: \_\_\_\_\_ Spouse's DOB: \_\_\_\_\_

**Primary Insurance Information please complete**

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of eligibility: \_\_\_\_\_  
Employer: \_\_\_\_\_ Emp Address: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_  
ID #: \_\_\_\_\_ Grp#: \_\_\_\_\_ Co-Pay Amount: \_\_\_\_\_  
Claim Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

**If you have additional insurance please complete the following**

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of eligibility: \_\_\_\_\_  
Emp: \_\_\_\_\_ Emp Address: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_  
ID #: \_\_\_\_\_ Grp#: \_\_\_\_\_ Co-Pay Amount: \_\_\_\_\_  
Claim Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

**If patient is a minor Parent or Guardian please complete**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
DOB: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext \_\_\_\_\_

I authorize release of any information concerning me (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

**X** \_\_\_\_\_  
Signature of patient or parent or guardian if minor

\_\_\_\_\_  
Date